EDITORIALS

The Medicaid Dilemma

TWO ARTICLES ELSEWHERE in this issue draw attention to the Medicaid (known in California as Medi-Cal) dilemma, a dilemma which so far has defied solution anywhere. Noble in concept and endorsed by the medical profession (at least in California) the Title XIX program was to provide "mainstream" medical care for the poor through a combination of federal and state funds. In spite of many difficulties, including a totally inadequate fee structure for physicians, the medical profession in California has continued to support this program and has even gone to court successfully in behalf of its beneficiaries.

In contrast to the Title XVIII Medicare program, which to a large extent was shaped through national debate over a period of years, Title XIX was passed by Congress almost as an afterthought, a "frosting on the cake," with a minimum of discussion about how it might operate or what might be its long-range implications. Perhaps as a consequence, Medicare has worked fairly smoothly in actual practice while Medicaid has been plagued with unforeseen problems which have yet to find satisfactory solution.

In California the thought was that if the state Medicaid program was to be done at all, it should be done right, with the poor being given genuine access to mainstream medical care and eliminating charity on the part of both physicians and hospitals which at that time had come to be described as demeaning. The result was that California established one of the most generous Medicaid programs in the nation with the full support of the California Medical Association which continues to believe that mainstream care for all is equitable and right.

The unforeseen problems which have developed are described by Myers and Leighton and by Heckman and Jones in this issue. Medical science has made mainstream care more effective and more costly whether for rich or poor. The ravages of inflation affect the value of government dollars for medical care as much as anyone else's. They buy less care for the same number of dollars, or they buy the same care for more dollars. Over the years the eligibility requirements in California for Medi-Cal have been modified until now 13 percent of the population of the state has entitlement. And it has been proved that restricting what is paid to physicians and bleating about fraud contribute little to solving the fundamental dilemma. The state of California is now putting its money on and into computerized billing, using an optical scanner billing form which will gather a great deal of information about services rendered as well as pay bills. So far this appears to be creating more problems than it is solving, and it certainly adds to the cost of the providers who are trying to give mainstream care to the beneficiaries of this program, often at a cost greater than the payments they may or may not receive for doing so.

The Medicaid dilemma is real enough—in California at least. More has been bitten off than can be readily chewed, let alone swallowed, digested or absorbed. Tension, stress and confrontation between government and the health care enterprise have been the order of the day almost since the inception of the program. All this confrontation has not been particularly useful or productive. Yet it is likely that all concerned would truly like to see all Californians have access to the same quality and quantity of medical care, which by definition would be mainstream care. If this is true, then one would hope that all parties with genuine interest might at some time get together, face up to the problems and agree on precisely what they are; agree on who needs to

do what about them; and then do what all will have agreed must be done. The disordered approach of the last decade or more simply has not worked well, nor is it likely that it ever will.

—MSMW

Evaluation of Asymptomatic Patients

PERIODIC HEALTH EXAMINATIONS (PHE's) are carried out in asymptomatic patients in an effort to prevent disease or to identify it at a very early stage. These encounters have contributed to a more complete patient data base and have facilitated physician-patient rapport, factors identified with improved patient care. A large, prospective study showed that death rates from certain "potentially postponable" disorders—such as hypertension and carcinoma of the colon—are reduced in those receiving PHE's.[1] Nonetheless, opponents have charged that the purported benefits of PHE's are not supported by firm scientific data.

Two recent reports provide PHE guidelines and shed light on the aforementioned criticism. An American Cancer Society report details recommendations for a "cancer-related checkup."[2,3] The report of the Canadian Task Force on the Periodic Health Examination[4] reviews the effectiveness of prevention and treatment of 78 conditions and lists recommendations based on sex, age and risk category.

In general, the recommendations point toward a "streamlined" PHE. For example, the American Cancer Society now advises that women over the age of 20, and those under 20 who are sexually active, have a Pap test "at least every three years, but only after they have had two negative Pap tests a year apart." The same report no longer recommends annual x-ray studies of the chest for the detection of lung cancer.

It should be noted that both reports have stirred controversy. Critics have observed that the guideline for x-ray studies of the chest is premature and in part based on preliminary data from ongoing prospective studies. The report of the Canadian Task Force does not recommend a "complete history and physical examination." This report refers to the studies on which its recommendations are based. For many crucial questions it is noteworthy that pertinent data are not available; hence the recommendations are often merely a summary of "expert opinion."

While physicians may take issue with specific recommendations, these reports merit careful study. Individual practitioners can then formulate PHE guidelines that are best suited for their patients. This will contribute to improved care and more efficient use of the health care dollar.

JOHN H. HOLBROOK, MD
Special Editor for Utah
Associate Professor
Department of Internal Medicine
University of Utah Medical Center
Salt Lake City

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Adenomatous Colonic Polyposis: To Lump or to Split?

WITH AN INCIDENCE of about one per 8,000 population, the familial polyposis disorders occur often enough that most physicians will encounter affected persons sometime during their practicing lifetimes. Whether these persons and their relatives are properly managed depends on a physician's familiarity with the manifestations of these disorders as well as with the genetic implications. Because several of these disorders predispose to carcinoma of the colon and rectum, the death of a patient or relative from cancer that might have been prevented at these sites represents a failure of medical care whether due to factors controllable by the patient, the physician or both.

Most of these disorders follow an autosomal dominant inheritance pattern so that they are not uniformly distributed in the population but are clustered in families. Recognition and proper diagnosis are hindered by poor history-taking, the preponderance of internal manifestations and the great variation of symptoms among affected persons, even among members of the same family.